

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7501	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2010
NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	<p>1200-8-6-.08(2) Building Standards</p> <p>(2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to comply with the Tennessee Department of Health Building Standards.</p> <p>The findings included:</p> <p>During the facility tour on 6/7/10 the following deficiencies were noted and verified by the Director of Maintenance.</p> <p>AT 12:00 PM, observation of the kitchen revealed 2 penetrations in the office wall. Tennessee Department of Health (TDOH). 1200-8-6.08(2)</p>	N 832	<p>N 832</p> <p>It is the policy and procedure of AdamsPlace that it complies with the applicable building and fire safety regulations. Plant Operations repaired the 2 penetrations in the office wall of the kitchen. Director of Plant Operations will do a QA weekly for 4 weeks to monitor for compliance.</p>	6/22/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

XFD821

If continuation sheet 1 of 1